AtlantiCare

A MEMBER OF GEISINGER HEALTH SYSTEM

BOOST

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shm project BOOST® Better Outcomes by Optimizing Safe Transitions

Malcolm Baldrige National Quality Award 2009 Award Recipient

About AtlantiCare

- Southern New Jersey's largest healthcare organization and largest non-casino employer, with more than 5,170 employees in nearly 70 locations.
- 621 bed, two campus teaching hospital
- Over 1500 Nurses; 70% BSN; 33% Certified
- More than 600 board-certified or board-eligible physicians

Learning Objectives

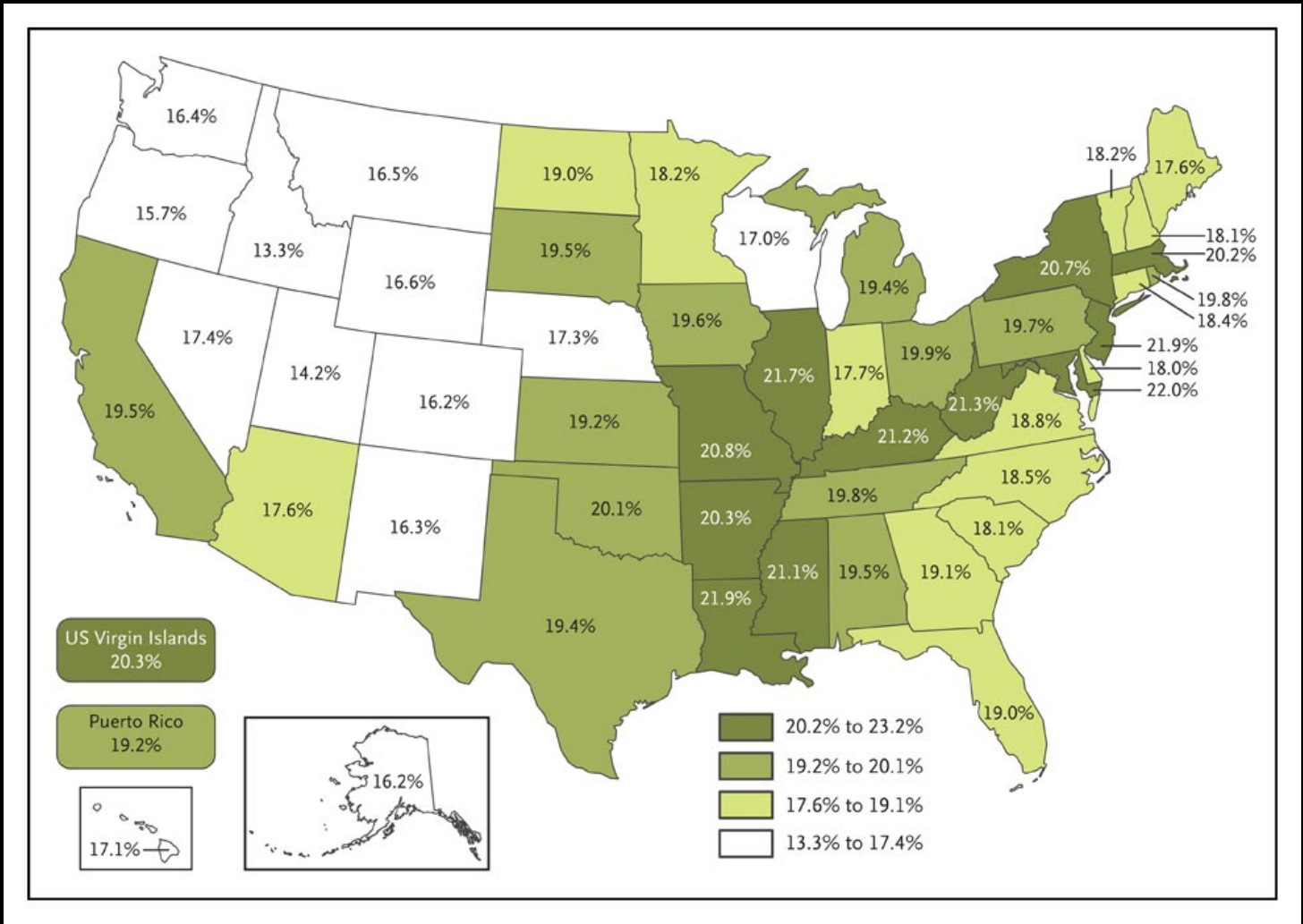
After this session the learner will be able to:

1. Define BOOST and the implications for nursing practice

1. List 2 ways that BOOST will reduce 30 day re-admissions


HOSPITAL
EXIT
HOSPITAL
ENTRANCE

Rates of Rehospitalization within 30 Days after Hospital Discharge



Jencks SF et al. N Engl J Med 2009;360:1418-1428

The NEW ENGLAND JOURNAL of MEDICINE

Strategies for Effectively reducing Readmissions*

- Plan earlier for hospital discharge
- Offer more intense education for new diagnosis
- Flag high-risk patients and provide case management
- Use multidisciplinary approach at discharge
- Check in with patients that have chronic conditions
- Provide follow up care
- Encourage connection with primary care providers

* 2013 Report From The Robert Wood Johnson Foundation

BOOST - The Vision

- Reduce 30 readmission rates for general medical patients
- Improve patient satisfaction scores and H-CAHPS scores related to discharge
- Improve flow of information from hospital and outpatient physicians and providers
- Identify high risk patients and target specific interventions to mitigate their risks for adverse events
- Improve patient and family preparation for discharge

BOOST Huddles - Unification

- Hospitalist
- Nursing
- Case Management
- Social Work
- Pharmacy
- PT
- Respiratory
- Palliative care

What do we want to accomplish in BOOST?

- Identify the PCP
- Open issues and obstacles to safe discharge
- Functional Status
- Disposition
- 8P Risk Assessment
- GAP Analysis
- 3 PM Huddle

Important Questions

- Who attends?
- Who leads the discussion?
- What is discussed?
- What preparation is required?
- When are the huddles?
- When do people speak?
- Where does the huddle occur?
- How do we handle interruptions?
- What are we measuring?
- How do we define success?
- Time constraints?
- Why huddle?

“The perfect is the enemy of the good.”

Voltaire

BOOST – The planning phase

What worked

- BOOST Training with SHM
- Mapping out the process
- Bringing all stake holders to the table for planning and input

What did not work

- Not having all the stake holders at the initial BOOST training with SHM
- Limited resources

BOOST – Education

What worked

- In servicing all Units
- In servicing all providers
- Healthstream education

What did not work

- Unclear who was missed

BOOST – Execution of the plan

What worked

- Geographic Hospitalist
- Simultaneous huddles
- Restricting huddle from 9:00 AM – 9:30AM daily
- Everyone has a voice
- Team member know what they are responsible for
- Restricting content
- Coming to huddle prepared
- Growing one floor at a time

What did not work

- Non Geographic Hospitalist
- Staggering huddle times
- Unrestricted time limit for huddles
- Restricting who can speak
- Team members not knowing the expectations
- Unrestricted content
- Not coming to huddle prepared
- Starting every unit at once

Opportunities

- Integration of consultants
- Limited resources
- Unanticipated changes
- Inertia

What happens after BOOST?

Risk Assessment: 8P Screening Tool

Old	New
1. Problem medications	1. Problem with medications
2. Psychological	2. Psychological
3. Principle Diagnosis	3. Principle Diagnosis
4. Polypharmacy	4. Physical Limitations
5. Poor health literacy	5. Poor health literacy
6. Patient support	6. Patient support
7. Prior hospitalization	7. Prior hospitalization
8. Palliative care	8. Palliative care

1. Problem With Medications

(polypharmacy ≥ 10 routine medications) or
(anticogulants,insulin,aspirin&plavix dual therapy,digoxin,narcotics)

- Medication specific intervention using Teach Back provided to patient and caregiver
- Monitoring plan developed and communicated to patient and aftercare providers
- Specific strategies for managing adverse drug events reviewed with patient/caregiver
- Simplification of scheduling to improve adherence
- Elimination of unnecessary medications
- Follow-up phone call at 72 hours to assess adherence and complications

2. Psychological

(depression screen positive or h/o depression diagnosis)

- Assessment of need for psychiatric aftercare if not in place
- Communication with aftercare providers, highlighting this issue if new
- Involvement/awareness of support network insured

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

3. Principle Diagnosis

(Cancer, Stroke, DM, COPD/Asthma, Heart Failure)

- Review of national discharge guidelines, where available
- Disease specific education using Teach Back with patient/caregiver
- Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms
- Discuss goals of care and chronic illness model discussed with patient/caregiver

4. Physical Limitations

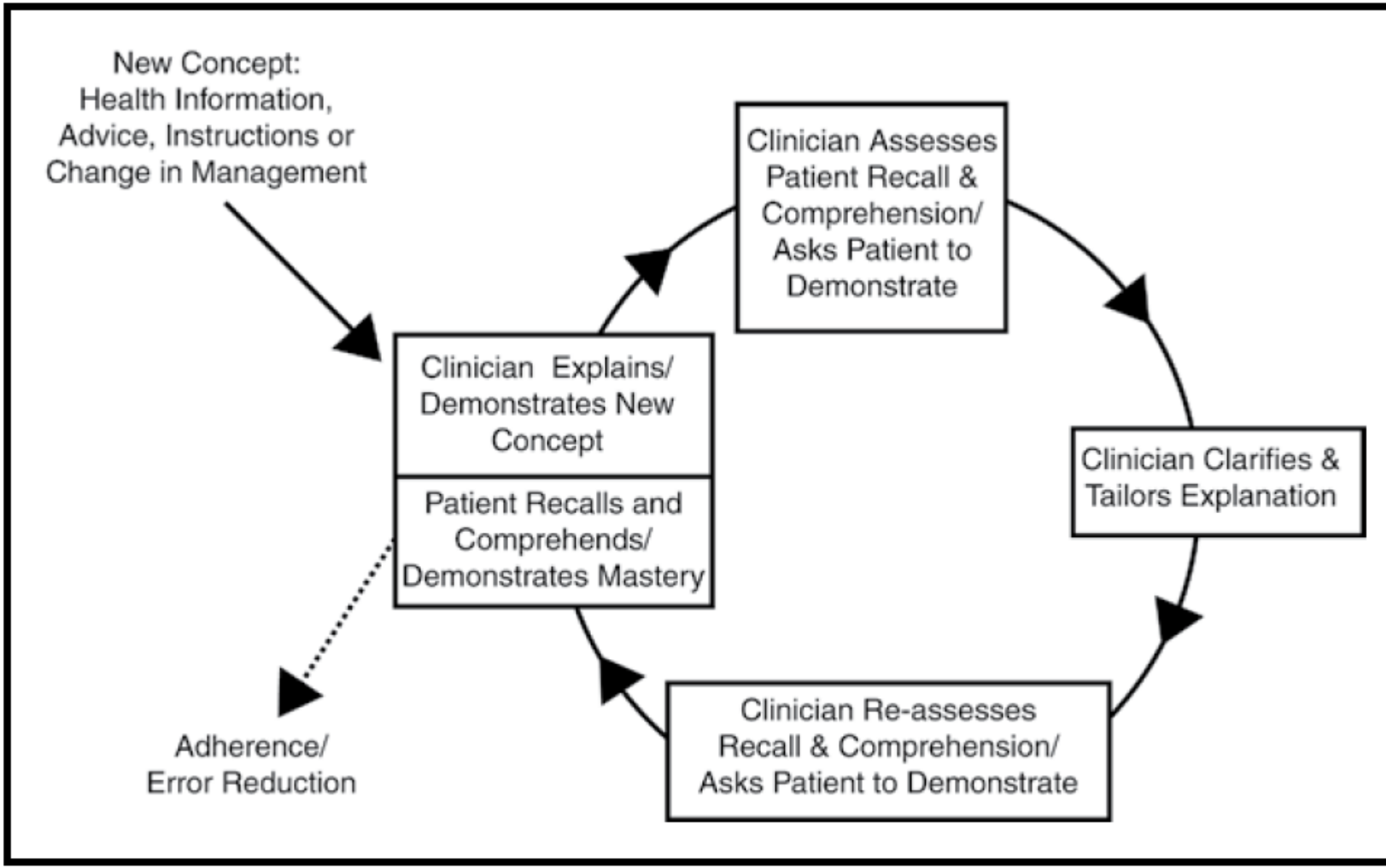
(deconditioning, frailty, or other physical limitations that impair ability to participate in their own care)

- Engage family/caregivers to ensure ability to assist in post-discharge care
- Assessment of home services to address limitations and care needs
- Follow-up phone call at 72 hours to assess ability to adhere to the care plan with services and support in place

5. Poor Health Literacy

(Inability to do Teach Back)

- Committed caregiver involved in planning/administration of all general and risk specific interventions
- Post-hospital care plan education using Teach Back provided to patient and caregiver
- Link to community resources for additional patient/caregiver support
- Follow-up phone call at 72 hours to assess adherence and complications



Schillinger, D, Piette J, Grumbach K, et al. Closing the loop: physician communication with diabetic patients who have low health literacy. **Arch Intern Med. 2003; 163:83-90**

6. Patient Support

(Absence of caregiver to assist with discharge and homecare)

- Follow-up phone call at 72 hours to assess condition, adherence and complications
- Follow-up appointment with aftercare medical provider within 7 days after hospitalization
- Involvement of homecare providers of services with clear communications of discharge plan to those providers
- Engage a transition coach

7. Prior Hospitalization

(non-elective, in last 6 months)

- Review reasons for re-hospitalization in context of prior hospitalization
- Follow-up phone call at 72 hours to assess condition, adherence and complications
- Follow-up appointment with aftercare medical provider within 7 days
- Engage a transition coach

8. Palliative Care

(Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) No to 1 Yes to 2:

- Assess need for palliative care services
- Identify goals of care and therapeutic options
- Communicate prognosis with patient/family/caregiver
- Assess and address concerning symptoms
- Identify services or benefits available to patients based on advanced disease status
- Discuss with patient/family/caregiver role of palliative care services and benefits and services available

General Assessment of Preparedness (GAP)

Prior to discharge, evaluate the following areas with the patient/caregiver(s) and ambulatory medical care providers: A = Beginning upon admission; P = Prior to discharge; D = At discharge

Logistical Issues

1. Functional status assessment completed (P) ❒ Yes ❒ No
2. Access (e.g. keys) to home insured (P) ❒ Yes ❒ No
3. Home prepared for patient's arrival (e.g. medical equipment, safety evaluation, food) ❒ Yes ❒ No
4. Financial resources for care needs assessed (P) ❒ Yes ❒ No
5. Ability to obtain medications confirmed (P) ❒ Yes ❒ No
6. Responsible party for insuring med adherence identified/prepared, if not patient (P) ❒ Yes ❒ No
7. Transportation to initial follow-up arranged (D) ❒ Yes ❒ No
8. Transportation home arranged (D) ❒ Yes ❒ No

Psychosocial Issues

1. Substance abuse/dependence evaluated (A) ❒ Yes ❒ No
2. Abuse/neglect presence assessed (A) ❒ Yes ❒ No
3. Cognitive status asserted (A) ❒ Yes ❒ No
4. Advanced care planning documented (A) ❒ Yes ❒ No
5. Support circle for patient identified (P) ❒ Yes ❒ No
6. Contact information for home caregivers obtained and provided to patient (D) ❒ Yes ❒ No

Confirmed by: _____ _____ ____/____/___

Signature | Print Name | Date

30 Day Readmission Study (n=400)

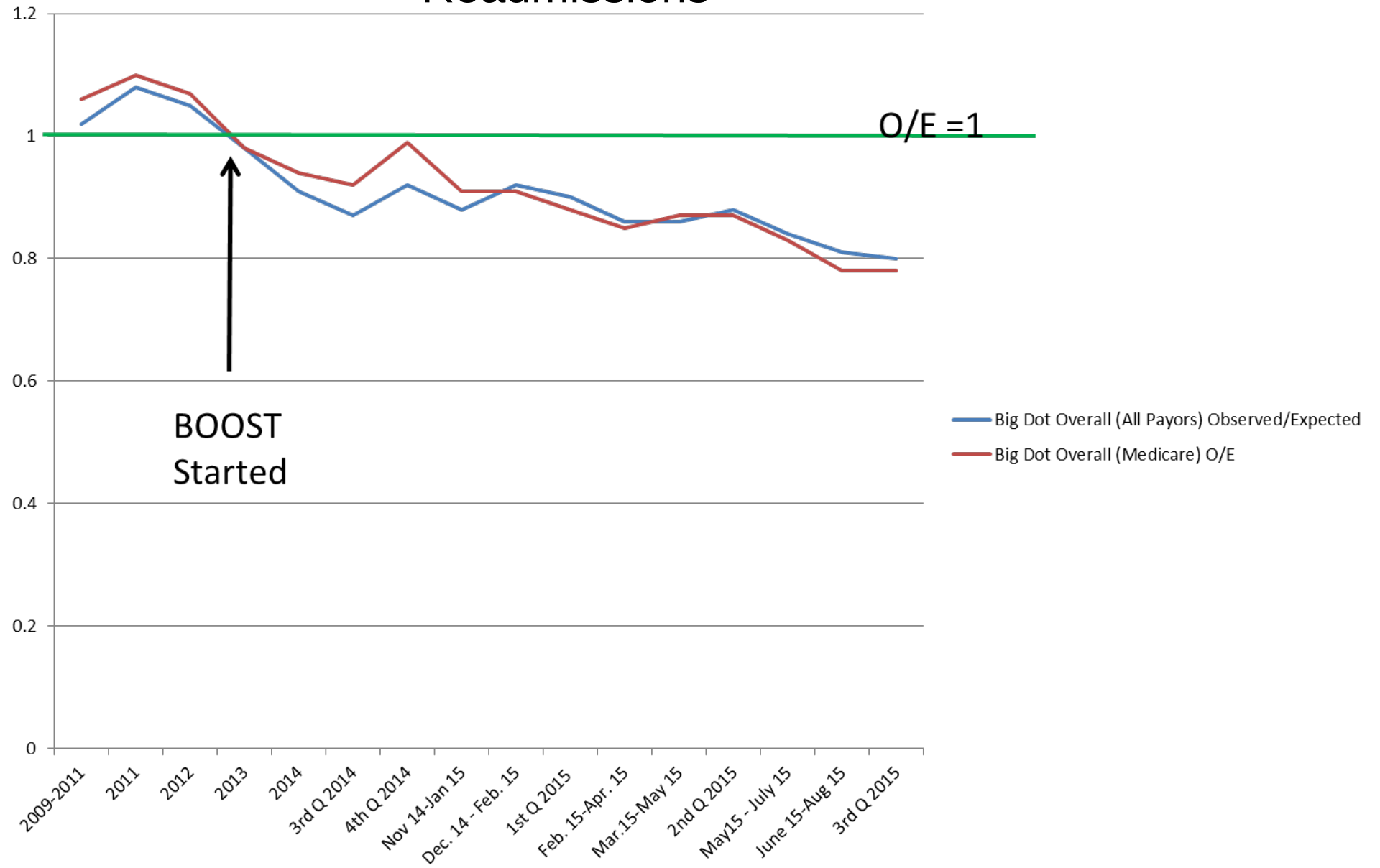
Study Completed July 2013

- February through June 2013
- 26 % Hospital Score ≥ 7
- 62 % Problem Medications
- 81 % Polypharmacy
- 78 % Prior Hospitalization within 6 months
- 25 % Problem Diagnosis
- 17 % Palliative Care
- 1.3 % homeless
- 6.5% uninsured
- 90 % had a Primary Care Physician

Relook Study August 2015

- February through June 2013
- 26 % Hospital Score ≥ 7
- 45 % Problem With Medications
- 14 % Polypharmacy
- 78 % Prior Hospitalization within 6 months
- 25 % Problem Diagnosis
- 17 % Palliative Care
- 79% Physical Limitations
- 1.3 % homeless
- 6.5% uninsured
- 90 % had a Primary Care Physician

Readmissions



Role of Nursing

- Helped to bridge relationships with the hospitalists
- Nurses' input is valued by the providers when we advocate for our patients.

- *"All voices are heard and the rounds are truly interdisciplinary- we get to touch base with PT, Pharmacy, case management, physicians, and nursing all at one time."*

Role of Nursing

- We get to plan and discuss complex discharge needs for patients as well as discuss follow up plans and resources the patients may need.
- We discuss high readmission risks for patients.

Implications for Nursing Practice

- Enhanced communication and relationships across the disciplines.

- The tools provide a format for ensuring that all aspects of care are covered to ensure the patient gets to the right care setting in a timely manner.

- Consistent, daily interaction between the nursing care team, case management and the hospitalist team, allowing for opportunity to discuss the patient plan and expedite discharge.

Interprofessional Team Participation

- Providers (Hospitalists, APNs, Residents)
- Nursing
- Case Management (RNs and Social Workers)
- Pharmacy
- Physical Therapy
- Palliative Care

Role of Case Management

- BOOST rounds makes discharge planning safe, efficient and cost effective.

We talk about the patients:

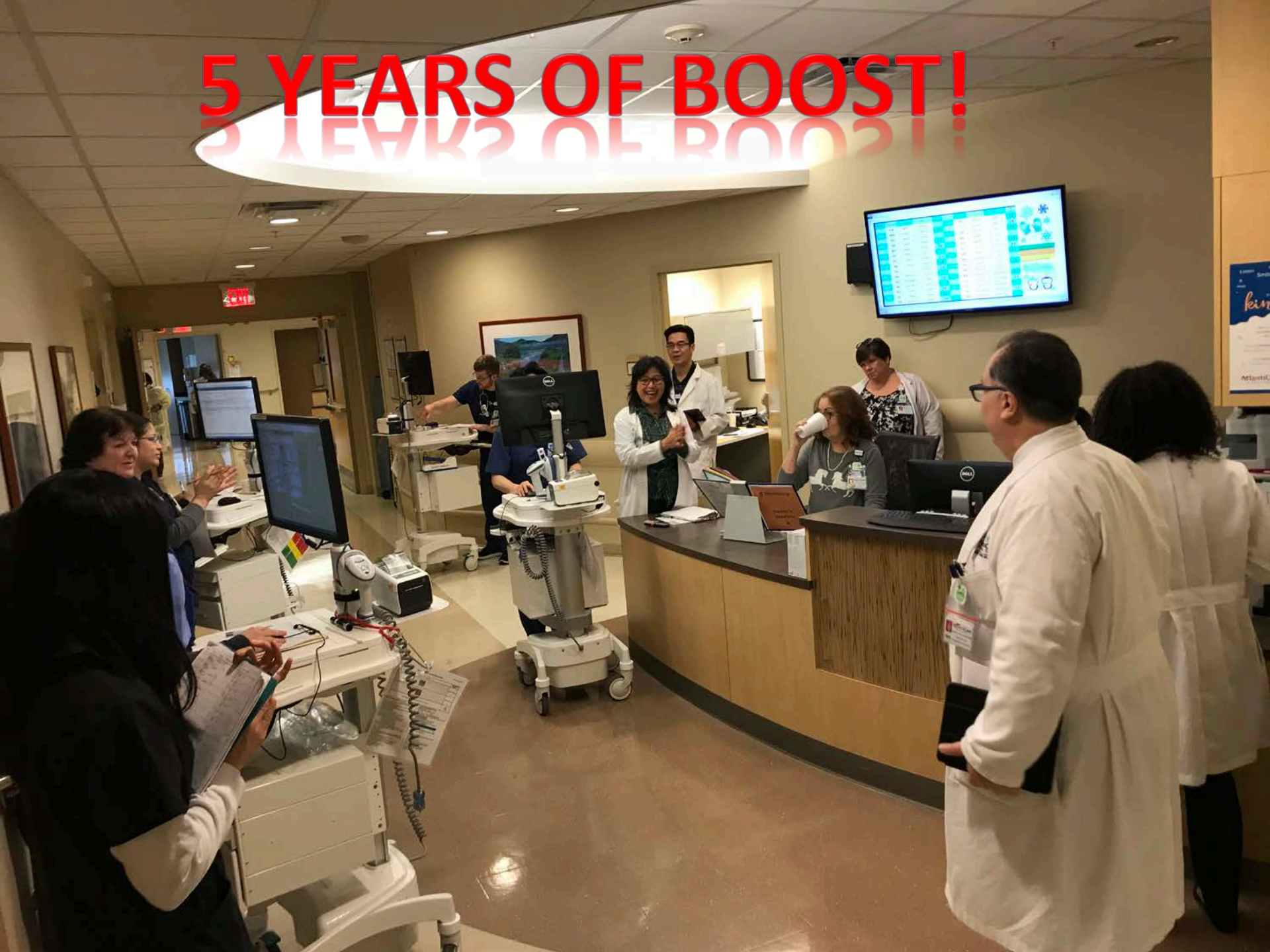
- Acute and Chronic illnesses
- Functional Status
- Family Support/Family Dynamics
- Insurance
- Care Coordination
- Community Resources
- Goals of Care (POLST or Advance Directive)

Role of Case Management

- BOOST rounds provides the Care Managers information in real time.

- BOOST rounds allows everyone to be on the same page.

“The strength of the team is each individual member. The strength of each member is the team.”


5 YEARS OF BOOST!

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